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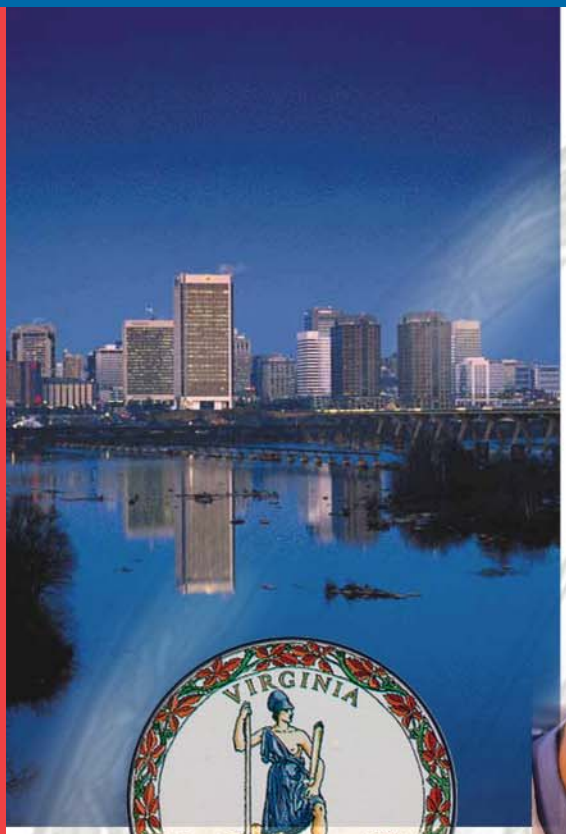

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Optima Family Care

Annual Report CY 2005

Improving Healthcare in the Communities We Serve.

Optima Family Care Annual Report

Introduction and Purpose

The Virginia Department of Medical Assistance Services (DMAS) is charged with the responsibility of evaluating the quality of care provided to recipients enrolled in contracted Medallion II managed care plans. The intent of the Medallion II program is to improve access to care, promote disease prevention, ensure quality care, and reduce Medicaid expenditures. To ensure that the care provided meets acceptable standards for quality, access, and timeliness, DMAS has contracted with the Delmarva Foundation for Medical Care, Inc. (Delmarva) to serve as the External Quality Review Organization (EQRO). This annual report will include the overall results of the Operational Systems Review as well as the findings related to quality, access and timeliness of care.

Following federal requirements for an annual assessment, as set for the in the Balanced Budget Act of 1997 (BBA) and federal EQRO regulations, Delmarva conducted a comprehensive review of MCO Name to assess the MCO's performance relative to the quality of care, timeliness of services, and accessibility of services.

For purposes of assessment, Delmarva has adopted the following definitions:

- **Quality,** stated in the federal regulations as it pertains to external quality review, is "the degree to which a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge" ("Final Rule: External Quality Review," 2003).

- **Access** (or accessibility), as defined by the National Committee for Quality Assurance (NCQA), is the "timeliness in which an organization's member can obtain available services. The organization must be able to ensure accessibility of routine and regular care and urgent and after-hours care" ("Standards and Guidelines," 2003).

- **Timeliness,** as it relates to utilization management decisions, is defined by NCQA as when "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation. The intent is that organizations make utilization decisions in a timely manner to minimize any disruption in the provision of health care" ("Standards and Guidelines," 2003). An additional definition

of timeliness given in the National Health Care Quality Report "refers to obtaining needed care and minimizing unnecessary delays in getting that care" ("Envisioning the National Health Care," 2001).

This annual report provides an evaluation of data sources reviewed by Delmarva as the EQRO to assess the progress that medallion II managed care plans have made in fulfilling the foals of DMAS. This annual report is a mandated activity in the Medallion II contract and the BBA External Quality Review regulations.

Although Delmarva's task is to assess how well Optima Family Care (Optima) performs in the areas of quality, access, and timeliness from Health Employer Data and Information Set (HEDIS®[1]) performance, performance improvement projects (PIPs), and operational systems review perspective, it is important to note the interdependence of quality, access, or timeliness also may be noted under either of the other two areas.

Quality, access and timeliness of care expectations for all persons enrolled in the Medallion II managed care program. Ascertaining whether health plans have met the intent of the BBA and state requirements is a major goal of this report.

Background on Plan

Optima Family Care provides managed care services to Medallion II enrollees in various localities throughout the state of Virginia. Enrollment in December 2005 for Optima health plan was 12,389 members. Localities covered by Optima are Tidewater, Central Virginia, Charlottesville, and Halifax regions. Optima began providing services to Medallion II enrollees in January 1996 and are an NCQA-accredited health plan with an excellent accreditation status.

Data Sources

Delmarva used three major data sources to evaluate the Optima performance:

- HEDIS, which is a nationally recognized set of performance measures developed by NCQA. These measures are used by health care purchasers to assess the quality and timeliness of care and service delivery to members of managed care delivery systems.
- Summaries of plan-conducted Performance Improvement Projects.
- Operational Systems Review, consisting of a pre-site and on-site review.

Methodology

Delmarva performed an external independent review of all data from the three sources above. The EQRO has assessed quality, access, and timeliness across the three data disciplines. After discussion of this

[1] HEDIS ®is a registered trademark of the National Committee for Quality Assurance.

integrated review, Delmarva will provide an assessment to DMAS regarding how well the health plan is providing quality care and services to its members.

The BBA requires that performance measures be validated in a manner consistent with the External Quality Review protocol *Validating Performance Measures*. Audits are to be conducted as prescribed by NCQA's *HEDIS 2005, Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures*[2] and is consistent with the validation method required by the EQRO protocols. Each Medallion II MCO uses NCQA protocols, including the Data Submission Tool (DST) to capture and compute its HEDIS results. The HEDIS data in this report have been taken directly from the Data Submission Tool (DST) completed by each MCO, but were not audited by Delmarva. This report contains data results of common HEDIS measures, each of which was calculated by all Medallion II managed care plans.

During the HEDIS 2006 reporting year, Medallion II MCOs collected data from calendar year 2005 related to the following clinical indicators as an assessment of quality, access, and timeliness:

- Childhood Immunization Status.
- Adolescent Immunization Status.
- Breast Cancer Screening.
- Prenatal and Postpartum Care.
- Well-Child Visits in the First 15 Months of Life.
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life.
- Adolescent Well-Care Visit.

PIPs also are used to assess the health plan's focus on quality, access, and timeliness of care and services. Although the PIPs address clinical issues, barrier analysis often leads to issues of access or timeliness as major contributing factors that affect the attainment of the clinical quality goals. During 2004, Optima implemented two PIPs, aimed at addressing clinical issues pertinent to the health plan's population. Delmarva reviewed the health plan's PIPs, assessed compliance with DMAS contractual requirements, and validated the activity for interventions as well as evidence of improvement. The PIP topics were as follows:

- Improving Overall Treatment and Utilization Patterns for the Health Management Asthma Population.
- Improving Treatment and Utilization Patterns for the Sentara Health Management Diabetes Population.

Optima's Operational Systems Review assessed activities performed by the MCO during the time frame of January 1, 2005 through December 31, 2005 (CY 2005). The purpose was to identify, validate, quantify, and monitor problem areas in the overall quality improvement program. The review incorporated regulations set

[2]The NCQA *HEDIS Compliance Audit*™ is a trademark of NCQA.

forth under the final rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in Section 1932 of the Social Security Act and Title 42 of the *Code of Federal Regulations* (CFR), part 438 *et seq.* in support of these regulations and health plan contractual requirements, Delmarva evaluated and then assessed compliance for the following systems:

- Enrollee Rights (ER) and Protections—Subpart C Regulation.
- Quality Assessment and Performance Improvement (QAPI)—Subpart D Regulation.
- Grievance Systems (GS)—Subpart F Regulation.

It is expected that each health plan will use the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

The operational systems standards used in the calendar year (CY) 2005 review were the same as those used in the 2004 review period (January 1, 2004-December 31, 2004) and in the 2003 review period (June- December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, these standards include regulations under Subparts C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "unmet." Only those elements that were not fully met in the 2003 review were assessed as part of the calendar year (CY) 2004 review. The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or unmet in the 2003 review. The CY 2005 review included a review of all operational systems standards as in prior reviews and was conducted on-site at the MCO as in the 2003 review.

Quality at a Glance

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population. The findings related to quality are reported in the following sections.

HEDIS

Three HEDIS measures served as proxy measures for clinical quality:

- Childhood Immunizations.

- Adolescent Immunizations.
- Breast Cancer Screening.

The HEDIS 2006 results are presented in Table 1 below.

Table 1. Measures of Quality –Childhood Immunization Status, Adolescent Immunization Status, and Breast cancer Screening Rates*

Measure	Optima	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Childhood Immunization Status Combination 2	70.5%	68.1%	62.9%
Adolescent Immunization Status Combination 2	40.4%	34.5%	38.4%
Breast Cancer Screening	58.6%	52.6%	54.0%

*Data in this table was submitted by the MCO and not validated by Delmarva.

Optima exceeded the HEDIS 2005 National Medicaid Average and the Medallion II Weighted Average for all three quality measures. While these measures exceed the averages, there is still room for improvement as the rates for these measures ranged from 40.4% for the Adolescent Immunization Status to 70.5% for the Childhood Immunization Status measure. It is therefore recommended that Optima continue its participation with the other Medallion MCOs in the collaborative project to improve immunization rates.

Performance Improvement Projects

Optima appropriately used the quality process of Performance Improvement Projects (PIPs) to identify a problem relevant to their health plan population. The PIP process also required setting a measurement goal, obtaining a baseline measurement, and performing targeted interventions aimed at improving the performance. After the remeasurement periods, qualitative analyses often identified new barriers that affect success in achieving the targeted goal. Thus, quality improvement is an ever-evolving process focused on improving outcomes and health status.

As in the 2004 review, all MCOs conducted a PIP targeting their population receiving treatment for asthma in 2005. This is an MCO system-wide initiative (enrollee, provider, and administrative) that presents potential barriers to improved enrollee health outcomes. Each MCO chose study indicators and data collection procedures that were based upon HEDIS measures and specifications.

A focus on asthma by each of the MCOs addresses an important opportunity for improvement in the member population based on review of Medicaid HMO plan-specific and national data. Asthma ranked in the top diagnoses for MCO inpatient admissions, emergency department visits, and outpatient office visits.

Optima was found to be in compliance with the DMAS contractual requirement for implementation of a second PIP during 2004. Optima implemented a PIP regarding improving diabetes care. This is an appropriate topic for selection based on the MCO's enrollee data. Since 2004 was considered a baseline year for submission of the second PIP, improvement was not assessed in the last annual review. For 2005, improvement in the indicators was assessed, when data for measurement year 2005 was provided. For Optima, 2005 data for the diabetes project was only available for two indicators at the time the project was submitted for review. Therefore, a full analysis has not been completed on this project for the Annual Report.

Performances on the PIPs are summarized in Table 2 below.

Table 2. PIP Performance Results for Optima*

PIP Activity	Indicator	Baseline	Remeasurement #1
		2004	2005
Improving Overall Treatment and Utilization Patterns for the Sentara Health Management Asthma Population	**Quantifiable Measure #1:** Percent of continuously enrolled Medicaid HMO enrollees with an inpatient admission for a primary diagnosis of asthma (ICD9 493.0-493.92)	4.1%	4.0%
	Quantifiable Measure #2: Percent of continuously enrolled Medicaid HMO enrollees with an emergency department visit for a primary diagnosis of asthma (ICD9 493.0-493.92)	20.7%	20.7%
	Quantifiable Measure #3: Percent of continuously enrolled members with asthma in the prior year that received an appropriate prescription in the reporting year.	67.7%	86.9%
		2004	2005
Improving Treatment and Utilization Patterns for the Sentara Health Management Diabetes Population	**Quantifiable Measure #1:** Hemoglobin A1c Test Rate	74.41%	78.60%
	Quantifiable Measure #2: Retinal Eye Examination Rate	41.98%	45.05%
	Quantifiable Measure #3: LDL Screening Rate	72.09%	72.97%

PIP Activity	Indicator	Baseline	Remeasurement #1
	Quantifiable Measure #4: LDL Control Rate	55.16%	56.76%
	Quantifiable Measure #5: Nephropathy Monitor Rate	37.58%	44.37%
	Quantifiable Measure #6: A1c Poor Control Rate	47.47%	42.57%
	Quantifiable Measure #7: Rate of Inpatient Admissions for a Primary Diagnosis of Diabetes	5.1%	6.4%
	Quantifiable Measure #8: Number of Emergency Department Visits for a Primary Diagnosis of Diabetes	6.6%	7.1%

*Data in this table was submitted by the MCO and was not validated by Delmarva.

An understanding of the quality improvement process, as it relates to PIPs was evidenced by Optima. Its Quality Improvement Activity (QIA) forms were comprehensive. The asthma PIP includes the three indicators in Table 2 above. A comparison of the baseline rate to the 2005 rates noted an improvement for two indicators (inpatient admissions and appropriate prescriptions) while the third indicator, emergency department admissions remained constant at 20.7%. It is noted that a decrease in the rate for inpatient admissions indicator (indicator #1), is a positive improvement.

The Improving Treatment and Utilization Patterns for the Sentara Health Management Diabetes Population project was submitted as the additional PIP required for the 2004 review. The first six indicators are HEDIS indicators. All of these indicators realized improvement, noting that a decrease in the A1c poor control is positive movement for the indicator. The two non-HEDIS indicators (rate of inpatient admissions and number of emergency room visits), both increased from 2004 to 2005 which is not positive movement of the indicator. Interventions implemented in the review year included (1) a reorganization of the Diabetes Management (DM) program to focus on specific metabolic and cardiovascular risk issues, (2) the addition of three full time RN's to expand program coverage, (3) the addition of two full time Patient Advisor Representatives, and (4) eliminating the referral requirement for diabetic eye exams to improve access.

Operational Systems Review

The standards that pertain to quality and were used to assess the Medallion II MCOs performance in the area of quality are listed below.

Enrollee Rights and Protections—Subpart C Regulations

- ER.1. Enrollee Rights and Protections-Staff/Provider.
- ER.6. Advanced Directives.

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA3. 438.206 Availability of Services (b) (3).
- QA5. 438.206 (c) (2) Cultural Considerations.
- QA6. 438.208 Coordination and Continuity of Care.
- QA11. 438.210 (b) Coverage and Authorization of Services—Processing of Requests.
- QA15. 438.214 (b) Provider Selection—Credentialing and Recredentialing Requirements.
- QA16. 438. 214 (c) Provider Selection—Nondiscrimination.
- QA17. 438.12 (a, b) Provider Discrimination Prohibited.
- QA18. 438.214 (d) Provider Selection—Excluded Providers.
- QA19. 438.56 (b) Provider Enrollment and Disenrollment—Requested by MCO.
- QA20. 438.56 (c) Provider Enrollment and Disenrollment—Requested by Enrollee.
- QA21. 438.228 Grievance Systems.
- QA22. 438.230 Subcontractual Relationships and Delegation.
- QA23. 438.236 (a, b) Practice Guidelines.
- QA24. 438.236 (c) Dissemination of Practice Guidelines.
- QA25. 438.236 (d) Application of Practice Guidelines.
- QA26. 438.240 Quality Assessment and Performance Improvement Program.
- QA27. 438.240 (b) (2) Basic Elements of Quality Assessment and Performance Improvement (QAPI) Program—Under/Over Utilization of Services.
- QA28. 438.240 (b) (3) Basic Elements of QAPI Program—Special Health Care Needs.
- QA29. 438.242 Health/Management Information Systems.

Grievance Systems—Subpart F Regulations

- GS1. 438.402 (a, b) Grievance System.
- GS2. 438.402 (3) Filing Requirements—Procedures.
- GS3. 438.404 Notice of Action.
- GS4. 438.404 (b) Content of Notice of Action.
- GS5. 438.416 Record-Keeping and Reporting Requirements.
- GS6. 438.406 Handling of Grievances and Appeals—Special Requirements for Appeals.

The following section provides a detailed assessment of the Medallion II MCO's performance in calendar year 2005 as it relates to the operational systems review findings for quality. This year's on-site review included an assessment of all elements and standards, whereas last year, the review focused only on those elements found to be deficient from the previous year.

Ensuring quality of care for Medicaid managed care recipients is a key objective of the Medallion II program. Various indicators exist that serve as direct and proximate measures of the quality of care and services provided to Medallion II recipients. Along with access and timeliness, these indicators are essential components of a quality-driven system of care, which is vital for the success of the Medallion II program. Data obtained from clinical studies performed by Delmarva as well as through other avenues of data support the delivery of quality health care to the Medallion II population.

In regards to quality, Optima performed well in the areas of enrollee rights, quality assurance and performance improvement, and grievance systems. Specifically in regards to the Enrollee Rights system, Optima has the required enrollee rights and responsibilities in place. Provider-enrollee communications are encouraged and not limited by the MCO. The Optima Member Guide describes all required benefits and services. Referral and authorization processes are in place and are monitored for timeliness. Members with special needs are allowed to have a specialist as their PCP and members can receive a second medical opinion at no cost. Compliant, grievances and appeals process are in place and appear to be functioning well. All of the standards for information and language requirements were met. Documentation was provided that readability requirements for member materials were met and interpretation and translation services are available. Adequate policies and procedures are in place to address enrollee confidentiality as required by HIPAA.

In the Quality Assessment and Performance Improvement standards, Optima also performed well. A case management program is in place to manage those members with certain high-risk conditions or needs. Continuity and coordination of care policies and procedures are in place for both physical and behavioral health. The credentialing and recredentialing process is comprehensive. Delegation policies and procedures are in place. Pre-delegation activities occur and there is monitoring of all delegates at least annually. Optima has preventive and disease specific clinical practice guidelines in place. The process to develop, implement, disseminate, and review guidelines is well established.

Processes are in place to monitor over and under utilization of services and use of technology protections-staff/provider, cultural considerations, dissemination of practice guidelines, basic elements of QAPI program, health/management information systems, and content of notice of action. Policies and procedures were revised for compliance in the areas shown above. An example of a significant area where Optima has performed successfully in this review is with cultural considerations.

In the last review, Optima was found to have opportunities for improvement in the areas of coverage and authorization of services, grievance systems and, notice of action. For coverage and authorization of services relating to the monitoring of the application of review criteria for authorizations and taking corrective action to ensure consistent application; a recommendation was provided. In the CY 2005 review, it was concluded

that health care professionals with the appropriate credentials are used to make utilization management decisions. Inter-rater reliability testing is conducted monthly in the areas of adherence to medical care policies, coding appropriateness, and policies requiring Medical Director authorizations. This addressed the concern identified in the CY 2004 review.
The Grievances System standards were all met. The notices of action and appeals packets provide members with all required information related to State Fair Hearings. Standards for resolving complaints, grievances, and appeals are in place and are monitored for timeliness. Expedited processes are in place to ensure timely decisions when there are extenuating circumstances.

Optima demonstrates a quality-focused approach in administering care and services to its members. The plan exhibits an integrated approach to working with its members, practitioners, providers, and internal health plan departments to improve overall health care quality and services. All Quality Assessment and Performance Improvement standards were met in 2005, except for one related to the provider anti-discrimination policy. This policy has already been modified in 2006 to address this deficiency.

Summary of Quality

Three HEDIS measures were used as proxy measures for quality; Childhood Immunization Status, Adolescent Immunization Status, and Breast Cancer Screening rates. These measures are seen as strengths for the MCO as Optima exceeded the HEDIS 2005 National Average and the Medallion II Weighted Average for all three measures. While these measures exceed the averages, there is still room for improvement as the rates for these measures ranged from 40.4% for the Adolescent Immunization Status to 70.5% for the Childhood Immunization Status measure.

The required PIPs have been developed and implemented according to timetables specified by DMAS. The project topics of asthma and diabetes are relevant for the MCO's population based on data analysis completed by the MCO. The asthma PIP noted an improvement for two indicators (inpatient admissions and appropriate prescriptions) while the third indicator, emergency department admissions, remained constant at 20.7%. The Diabetes PIP included six HEDIS indicators; all six indicators improved from the baseline period of 2004. The two non-HEDIS indicators (rate of inpatient admissions and number of emergency room visits), both increased from 2004 to 2005 which is not positive movement of the indicator. Interventions implemented in the review year included (1) a reorganization of the Diabetes Management (DM) program to focus on specific metabolic and cardiovascular risk issues, (2) the addition of three full time RN's to expand program coverage, (3) the addition of two full time Patient Advisor Representatives, and (4) eliminating the referral requirement for diabetic eye exams to improve access.

Optima met the requirements for all but one of the 19 Quality Assessment and Performance Improvement standards related to quality. The only standard that was not fully met noted that policies and procedures did not ensure that the MCO would not discriminate against particular providers that serve high-risk populations

or specialize in conditions that require costly treatment. Optima revised its Network Composition Policy in January 2006 and now it includes the required provisions. Optima met all the requirements for the two Enrollee Rights and six Grievance Systems standards used to assess quality in this review.

Access at a Glance

Access is an essential component of a quality-driven system of care, and historically has been a challenge for Medicaid recipients enrolled in fee-for-service programs. The intent of the Medallion II program is to improve access to care. One of DMAS's major goals in securing approval of the 1915(b) Medicaid waiver application was to develop managed care delivery systems that would remove existing barriers for Medicaid recipients, thereby improving their overall health status, increasing their quality of life, and reducing costly health expenditures related to a fragmented system of care. The findings with regard to access are described below.

HEDIS

The HEDIS performance measures are used to evaluate access and availability of care through the Prenatal and Postpartum Care results as compared with both the Medallion II and the NCQA HEDIS Medicaid averages. Two rates are calculated for this measure:

- Timeliness of Prenatal Care[3].
- Postpartum Check-up Following Delivery[4].

Table 3 provides the HEDIS results for the Medallion II MCOs for these two measures pertaining to access.

Table 3. Access Measures - Prenatal and Post Partum Care*

Measure	Optima	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Timeliness of Prenatal Care	84.0%	84.1%	78.3%
Postpartum Care	59.3%	59.9%	55.9%

***Data in this table was submitted by the MCO and not validated by Delmarva.**

Optima's rates for both HEDIS access measures related to prenatal and postpartum care exceeded the HEDIS 2005 National Medical Average. Both measures, however, fall slightly below the Medallion II

[3] Timeliness of Prenatal Care measures the percentage of women in the denominator who received a prenatal care visit in the first trimester or within 42 days of enrollment.
[4] Postpartum Check-up Following Delivery measures the percentage of women in the denominator who had a postpartum visit on or between 21 days and 56 days following delivery.

Weighted Average. The Medallion II Weighted Average is also above the HEDIS 2005 National Medicaid Average for both measures.

Performance Improvement Projects

The PIPs implemented by the Medallion II MCOs focused on improvement of clinical indicators. However; within the barrier analyses for each project, potential access barriers also were examined. The following section provides an MCO level specific summary of access issues identified by Optima.

Optima's asthma PIP targeted increasing the number of members with asthma receiving care according to clinical guidelines. The PIP also identified access barriers related to member and provider lack of awareness of benefits related to a chronic disease, such as asthma. Interventions implemented in 2005 included expanding educational workshops throughout Optima's coverage area, employing an additional full time asthma case manager to expand coverage to members, and developing and implementing an electronic case management tool to track services to members with asthma.

As part of its diabetes PIP, Optima implemented interventions to improve access to services for diabetic members. Specifically, Optima (1) a reorganized the Diabetes Management (DM) program to focus on specific metabolic and cardiovascular risk issues, (2) added three full time RN's to expand program coverage, (3) added two full time Patient Advisor Representatives, and (4) eliminated the referral requirement for diabetic eye exams.

In regards to the diabetes project, access barriers were identified. Interventions to address these barriers were implemented in 2005 an include eliminating the need for a referral for a diabetic eye examination, three full time employees were hired to expand coverage of the diabetes disease management program, an additional staff member was added to Cardiovascular Management Disease Management Program to provide a more coordinated approach to member with diabetes who often have complex metabolic cardiovascular risk issues, and two new Patient Advisor Representatives were hired to increase member access to services.

Operational Systems Review

In 2004, as part of a desk-review, Delmarva comprehensively reassessed elements from the previous year's review that previously were not fully met and found that the majority of all elements had improved to a met status. In 2005, Delmarva reassessed all elements and standards as part of the Operational Systems Review. Delmarva's Operational Systems Review of the Medallion II MCOs evaluated elements pertaining to access in the following required review categories. These elements pertain to this and last year's review to provide a complete evaluation of the Medallion II MCOs performance in the area of access. The following standards were used to assess the MCOs compliance with access standards.

Enrollee Rights and Protections—Subpart C Regulations

- ER3. Information and Language Requirements (438.10).
- ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).
- ER7. Rehabilitation Act, ADA.

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA1. 438.206 Availability of Services (b).
- QA2. 438.206 Availability of Services (b) (2).
- QA4. 438.206 Availability of Services (b) (4).
- QA7. 438.208 (c) 103 Additional Services for Enrollees with Special Health Care Needs.
- QA8. 438.208 (c) (4) Direct Access to Specialists.
- QA10. 438.208 (e) Primary Care and Coordination Program.

Optima met all the Enrollee Rights and Quality Assessment and Performance Improvement standards above related to access. Optima performed well in the area of information and language requirements, emergency and post-stabilization services, and the Rehabilitation Act requirements. All MCOs also performed well in the areas of availability of services, access to specialists, and primary care coordination.

Through the pre-site and on-site review conducted for Optima, Delmarva comprehensively assessed elements for CY 2005. Optima performed well in areas of access to include an element relating to information and language requirements, emergency and post-stabilization services, the Rehabilitation Act, and direct access to specialists. There was evidence that policies and procedures were revised prior to this review to ensure compliance with standards that were not fully met in the CY 2004 review.

In the CY 2004 review, Optima performed well in the areas of information and language requirements, emergency and post-stabilization services, and availability of services. It was also noted that policies and procedures were revised prior to this review to ensure compliance within these areas. These standards remain met for the CY 2005 review.

Optima continues to perform well in the areas of information and language requirements. Optima has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Optima provides an in-home member education session for members who are visually impaired and a closed-captioned member education video for those who are hearing impaired.

Members are ensured access to various services through policies and procedures. Specifically, members have access to out-of-network and out-of-area services. Female members are allowed to obtain an annual gynecological examination ad well as confidential family planning and birth control services from any

participating provider without a referral. Finally, enrollees have access to a second opinion from a qualified health care professional at no cost to the enrollee. Optima also has a comprehensive set of member confidentiality and protected health information policies that meet DMAS and HIPAA requirements.

Optima has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed. Optima has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their primary care provider (PCP) be a specialist.

In the last review, a recommendation was provided for changes to member information, language requirements, and policies related to the Rehabilitation Act. It was recommended that Optima revise its policies to include procedures for informing enrollees about the availability of alternative formats for MCO information with instructions on how to obtain those formats. Optima submitted a revised Interpreter and Translation Services policy in CY 2005 that addressed this recommendation.

Overall, access is an area of strength for Optima and supports the health plan's intent as a quality-driven system of care. Optima addressed the areas where it showed vulnerability and corrected identified access issues, furthering the plan in its goal to implement a managed care delivery system that addresses existing barriers for Medicaid recipients.

Summary of Access

Overall, access is an area of strength for Optima and supports the health plan's intent as a quality-driven system of care. Optima's rates for both HEDIS access measures related to prenatal and postpartum care exceeded the HEDIS 2005 National Medical Average. The Timeliness of Prenatal Care measure also exceeded the Medallion II Weighted Average. However; the Postpartum Care rate of 59.3% falls slightly below the Medallion II Weighted Average of 59.9%. The Medallion II Weighted Average is also above the HEDIS 2005 National Medicaid Average for both measures. As in last year's review, these access measures are an area of strength for the MCO.

Optima developed and implemented PIPs related to asthma and diabetes care which are relevant to its population. The MCO followed the quality improvement project process and implemented additional interventions in 2005 to address identified barriers. The 2005 results for the asthma project indicators were available, but the majority of indicators for the diabetes project were not.

Optima's asthma PIP targeted increasing the number of members with asthma receiving care according to clinical guidelines. Interventions implemented in he review year targeted access issues including expanding educational workshops throughout Optima's coverage area, employing an additional full time asthma case

manager to expand coverage to members, and developing and implementing an electronic case management tool to track services to members with asthma.

In regards to the diabetes project, access barriers were identified. Interventions to address these barriers were implemented in 2005 an included eliminating the need for a referral for a diabetic eye examination, and adding staff to expand coverage of the diabetes disease management program.

Enrollee Rights and Quality Assessment and Performance Improvement standards were used to assess the dimension of access. Optima met the requirements for all standards for all of these standards for the CY 2005 review.

Timeliness at a Glance

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal, established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections that follow.

HEDIS

Timeliness of care was investigated in the results of the following HEDIS measures, which the Medallion II MCOs (except AMERIGROUP) were required to submit:

- Well-Child Visits in the First 15 Months of Life[5].
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life[6].
- Adolescent Well-Care Visits[7].

Table 4 provides the HEDIS measure results for the Medallion II MCOs pertaining to timeliness.

[5] Well-Child Visits in the First 15 Months of Life measures the percentage of enrolled members who turned 15 months old during the measurement year, who were continuously enrolled in the Plan from 31 days of age, and who received six or more well child visits with a primary care practitioner during their first 15 months of life.
[6] Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life measures the percentage of members who were three, four, five or, six years old during the measurement year, who were continuously enrolled during the measurement year, and who received one or more well-child visit(s) with a primary care practitioner during the measurement year.
[7] Adolescent Well-Care Visits measures the percentage of enrolled members who were age 12 through 21years during the measurement year who were continuously enrolled during the measurement year and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Table 4. Timeliness Measures- Well Child Visits and Adolescent Well Care*

Measure	Optima	Medallion II Weighted Average CY 2005	HEDIS 2005 National Medicaid Average
Well Child Visits in the First 15 Months of Life (6 or more visits)	47.3%	47.3%	46.8%
Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life	61.1%	59.7%	61.9%
Adolescent Well Care	29.5%	29.6%	40.3%

* The data in this table was submitted by the MCO and was not validated by Delmarva.

The rate for the Well Child Visits in the First 15 Months of Life measure for Optima is equal to the Medallion II Weighted Average and exceeded the HEDIS 2005 National Medicaid Average. The Medallion II Weighted Average for this measure was 47.3%, which exceeds the HEDIS 2005 National Medicaid Average of 46.8%.

Optima's rate for the Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life measure was 61.1% which is slightly above the Medallion II Weighted Average (59.7%), but below the HEDIS 2005 National Medicaid Average (61.9%). None of the Medallion II MCOs met or exceeded the Medicaid HEDIS 2005 National Average.

The Adolescent Well Care measure was 29.5% for Optima. This falls slightly below the Medallion II Weighted Average (29.6%) and is well below the HEDIS 2005 National Medicaid Average of 40.3%.

One of the three HEDIS measures that assessed timeliness was equal to, one was below and one exceeded the Medallion II Weighted Average. One was above the HEDIS 2005 National Medicaid Average while the remaining two were below this average. This represents an area of opportunity for Optima.

Performance Improvement Projects

In 2004, timeliness was a focal area of attention in the Medallion II MCO PIPs. Member-focused efforts consisted of member education about the key features of asthma and diabetes management as chronic diseases. Provider-focused efforts aimed at establishing partnerships with the practitioner network to address education about asthma and diabetes in the member population. Barriers related to timeliness issues focus on the lack of timely delivery of care or services due to missed opportunities.

Several interventions were implemented in 2005 for the asthma project. One specifically addressed timeliness and included the implementation of an electronic charting tool. This tool, when fully implemented, will allow

staff to keep an electronic record of member contacts and services so that staff can communicate information to each other timely and accurately.

In 2005, many of the same barriers related to access, including members not receiving recommended diabetic testing (e.g. HbA1c and dilated retinal eye examination), continued to be identified. New interventions were developed which focused on adding additional staff to expand educational efforts, increase coverage area and to eliminate the need for a referral for a diabetic eye examination.

Operational Systems Review

Access to necessary health care and related services alone is insufficient in advancing the health status of Medallion II recipients. Equally important is the timely delivery of those services, which is an additional goal, established by DMAS for the systems of care that serve Medallion II recipients. The findings related to timeliness are revealed in the sections to follow. Delmarva assessed the Enrollee Rights, Quality Assessment and Performance Improvement, and Grievance System standards to evaluate Optima's commitment to timeliness of services.

Delmarva's operational systems review of the Medallion II MCOs assessed and documented elements pertaining to timeliness in the following review requirement categories. These elements pertain to the 2005 and last year's review to provide a complete evaluation of the Medallion II MCOs performance in the area of timeliness. Standards used to assess the Medallion II MCOs compliance with timeliness are included below.

Enrollee Rights and Protections—Subpart C Regulations

- ER2. Written Statement Upon Enrollment.
- ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (Privacy and Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996.

Quality Assessment and Performance Improvement—Subpart D Regulations

- QA9. 438.208 (d) (2) (ii-iii) Referrals and Treatment Plans.
- QA11. 438.210 (b) Coverage and Authorization of Services—Processing of Requests.
- QA12. 438.210 (c) Coverage and Authorization of Services—Notice of Adverse Action.
- QA13. 438.210 (d) (1) Timeframe for Decisions—Standard Authorization of Decisions.
- QA14. 438.210 (d) (2) Timeframe for Decisions—Expedited Authorization Decisions.

Grievance Systems—Subpart F Regulations

- GS7. 438.408 Resolution and Notification: Grievances and Appeals—Standard Resolution.
- GS8. 438.408 Resolution and Notification: Grievances and Appeals—Expedited Resolution.
- GS9. 438.408 (b-d) Resolution and Notification.
- GS10. 438.408 (c) Requirements for State Fair Hearings.

- GS11. 438.410 Expedited Resolution of Appeals, GS. 438.424 Effectuation of Reversed Appeal Resolutions.

Optima met the requirements for all of the standards related to timeliness listed above. In general, Optima performed well in the areas of coverage and authorization of services, resolution and notification for grievances and appeals, and provision of information to members regarding State Fair Hearing timeliness requirements. Timeframes for completion of grievances and appeals are consistent with requirement. The Services Requiring Authorization and Timeframes for Decisions policy outline all of the required decision timeframes and monitoring efforts. Optima performed well on the timeliness measures. An expedited authorization process is in place to allow members with special circumstances to receive an expedited decision.

In the CY 2004 review, it was recommended that Optima revise the Services Requiring Authorization and Timeframes for Decisions policy to include the extension time frame for expedited authorizations provided in the Medallion II Managed Care Contract. A revised Services Requiring Authorization and Timeframes for Decisions policy was subsequently submitted and now meets the requirement for this standard.

Optima demonstrates an awareness of the importance of timeliness in the delivery of overall quality care and service through the identification of timeliness barriers, which often are identified as access issues. Optima continues to incorporate recommendations made by Delmarva that have resulted in the MCO meeting all standards related to timeliness of care.

Summary of Timeliness

Three measures collected by the MCO assess the timeliness of care provided by Optima; Well Child Visits in the First 15 Months of Life, Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life and Adolescent Well Care. The rate for the Well Child Visits in the First 15 Months of Life measure for Optima equal to the Medallion II Weighted Average and exceeded the HEDIS 2005 National Medicaid Average. Optima's rate for the Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life measure was slightly above the Medallion II Weighted Average but below the HEDIS 2005 National Medicaid Average. The Adolescent Well Care measure rate fell slightly below the Medallion II Weighted Average and is well below the HEDIS 2005 National Medicaid Average. These measures represent an opportunity for improvement for Optima.

Through its projects on asthma and diabetes, Optima has identified barriers related to timeliness. In order to address these issues, interventions have been developed and include eliminating referrals for services, adding staff to and restructuring its disease management and other programs (e.g. education), as well as implementing electronic systems to record and transfer accurate and complete patient data on a timely basis.

Optima continues to incorporate recommendations made by Delmarva that have resulted in the MCO meeting all of the Operations Systems Review standards related to timeliness of care.

Overall Strengths

Quality:

- Optima exceeded the HEDIS 2005 National Medicaid Average and the Medallion II for all three quality measures.
- The diabetes project realized a positive movement in six of the eight indicators.
- Interventions implemented for the diabetes project included the removal of administrative barriers (referrals) for dilated eye examinations for diabetic members. This is one of the indicators that realized and increase from 2004 to 2005.
- Optima fully met the requirements for all Enrollee Rights and Grievance Systems standards used to assess quality for this review.
- Eighteen of the 19 Quality Assessment and Performance Improvement standards used to assess quality were met.
- Provider-enrollee communications are encouraged and not limited by the MCO.
- A case management program is in place to manage those members with certain high-risk conditions or needs.
- Continuity and coordination of care policies and procedures are in place for both physical and behavioral health.
- The credentialing and recredentialing process is comprehensive.
- Delegation policies and procedures are in place. Pre-delegation activities occur and there is monitoring of all delegates at least annually.
- Clinical practice guidelines are in place. The process to develop, implement, disseminate, and review guidelines is well established.
- Inter-rater reliability testing is conducted monthly in the areas of adherence to medical care policies, coding appropriateness and policies requiring Medical Director Authorization.
- Processes are in place to monitor over and under utilization of services and use of technology.

Access:

- In the two HEDIS measures used as proxies for access, Timeliness of Prenatal Care and Postpartum Care, Optima's rates exceeded the HEDIS 2005 Medicaid National Average.
- Interventions implemented for the diabetes project included the removal of administrative barriers (referrals) for dilated eye examinations for diabetic members. This is one of the indicators that realized and increase from 2004 to 2005.

- Optima fully met the requirements for all three Enrollee Rights and six Quality Assessment and Performance Improvement standards used to assess access for this review.
- The MCO's PIP focusing on asthma included interventions specifically targeted to improve access to the program. These interventions included individual contact with members.
- Both the asthma PIP and diabetes PIP identified access barriers. Interventions were implemented in 2005 to address access issues identified.
- The Optima Member Guide is comprehensive and includes all required information to ensure member access to benefits and services.
- All required access standards and mechanisms to monitor these standards are in place.
- Processes are in place to ensure member access to out-of-network and out-of-areas services.
- Enrollment and disenrollment policies and procedures are in place.
- Policies and procedures are in place to ensure that members who are non-English speaking, have limited English proficiency or who have special needs (e.g. visual impairments) have vital documents translated, have access to interpretation and translation services, and have information provided at the appropriate reading level.
- Access to protected health information (PHI) and member confidentiality is appropriately controlled through internal policies and procedures that are in compliance with HIPAA regulations.
- Policies and procedures are in place for members to access emergency and post-stabilization services.
- Members are ensured access to care 24 hours per day, seven days per week. Access is monitored at least annually to ensure PCP compliance.
- Enrollees have access to a second opinion from a qualified health care professional at no cost to the enrollee.
- Female members are allowed to obtain an annual gynecological examination ad well as confidential family planning and birth control services from any participating provider without a referral.
- Enrollees with special needs can have a specialist as their PCP.

Timeliness:

- One of the HEDIS measures used as a proxy for timeliness, Well Child Visits in the First 15 Months of life (6 or more visits), was equal to the Medallion II Weighted Average and exceeded the HEDIS 2005 National Medicaid Average.
- The Well Child Visits in the 3rd, 4th, 5th, and 6th Year of Life Measure exceeded the Medallion II Weighted Average.
- Optima met all of the Enrollee Rights, Quality Assessment and Performance Improvement and Grievance Systems Standards related to timeliness.
- The pre-authorization policies and procedures address timeliness of decisions. There are processes in place to monitor timeliness of decisions.
- The Services Requiring Authorization and Timeframes for Decisions policy outline all of the required decision timeframes and monitoring efforts.

- An expedited authorization process is in place to allow members with special circumstances to receive an expedited decision.
- The grievance system is established and appears to be functioning well. Timeframes for completion of grievances and appeals are consistent with requirements and are monitored for compliance to these standards.

Recommendations

This section offers DMAS a set of recommendations to build upon identified strengths and to address the areas of opportunity within the existing programs. These recommendations draw from the findings of those data sources individually and in the aggregate. Delmarva's recommendations for Optima are as follows:

HEDIS measures can provide an MCO with valid and reliable data for planning purposes. The HEDIS measures used as proxies for quality included Childhood Immunization Status (Combination 2), Adolescent Immunization Status (Combination 2), and Breast Cancer Screening. Optima exceeded the HEDIS 2005 National Medicaid Average and the Medallion II for all three quality measures. While these measures exceed the averages, there is still room for improvement as the rates for these measures ranged from 40.4% for the Adolescent Immunization Status to 70.5% for the Childhood Immunization Status measure. It is therefore recommended that Optima continue its participation with the other Medallion II MCOs in the collaborative project to improve immunization rates. It is also recommended that Optima further investigate the need for a project on breast cancer screening or at a minimum conduct a barrier analysis.

Of the three HEDIS measures that assessed timeliness, Well Child Visits in the First 15 Months of Life at 47.3% was equal to the Medallion II Weighted Average and exceeded the HEDIS National Medicaid average of 46.8%. The Adolescent Well Care measure at 29.5% was only slightly below the Medallion II Weighted Average and below the HEDIS National Medicaid average of 40.3 %. Well Child Visit in the 3rd, 4th, 5th, and 6th Year of Life at 61.1% exceeded the Medallion II Weighted Average of 59.7% and only slightly below the HEDIS National Medicaid average of 61.9%. As recommended, Optima should review these measures and determine the need for a quality improvement project related to well child and adolescent well care visits.

PIPs provided for review include asthma and diabetes. The asthma PIP includes three indicators. An improvement an improvement was noted for two indicators (inpatient admissions and appropriate prescriptions) while the third indicator, emergency department admissions remained constant. All six of the diabetes project indicators improved. However, since the data was just compiled by Optima for the HEDIS indictors for these two projects, it is recommended that the MCO complete another barrier analysis to determine the need for additional interventions or the need to continue with current interventions.

It is recommended that Optima also continue its collaborative efforts with the other Medallion II MCOs in implementing an immunization project.

Only one of the Operational Systems Review standards was not fully met by Optima which related to provider non-discrimination. To receive a determination of met in future reviews, Optima must ensure that the Network Composition Policy, as revised in January 2006, continues to include the policies and procedures that ensure the MCO will not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

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